DEPARTMENT OF HUMAN RESOURCES
DIVISION OF HEALTH CARE FINANCING AND POLICY - NEVADA MEDICAID FOCIS UNIT
1100 East William Street Ste 102
Carson City, Nevada 89701
FAX (775)-687-8724

MONTHLY FACILITY OCCUPANCY REPORT

THIS FORM MUST BE IN OUR OFFICE BY THE 5TH DAY OF EVERY MONTH

Facility Name:_____

Instructions:

Nursing Facilities (NF) and Intermediate Care Facilities for the Mentally Retarded (ICF/MR) statewide must complete this form to reflect the exact facility census as of midnight (00:00 hour) on the first day of every month. The form may be faxed, mailed or submitted on-line (see instructions) and must be received at Nevada Medicaid by the fifth day of the month. The facility must retain a copy for their records.

All areas must be filled in, or enter "O" or "N/A". Grand Total Census, plus vacancy total, should equal the number of certified beds. If not, indicate below the number of beds not available for occupancy.

Service Level	OCCUPIED BEDS BY PAYMENT SOURCE					
	MEDICAID	MEDICARE	COUNTY	PRIVATE	VA	
NF STANDARD						
VENTILATOR DEPENDENT						
NF PEDS SPECIALITY CARE I						
NF PEDS SPECIALITY CARE II						
ICF/MR						
TOTAL	+	+	+	+	+	= Grand Total Census

Number of vacancies:_____

Total number of Medicare/Medicaid certified beds for this facility:_____

***If certification has changed this month, please attach copy of certification to this form.**

Number of additional certified beds that are not available for occupancy:_____

Reason bed unavailable: _____

I certify as of midnight (00:00) on _____, (must be the first day of the month) the above information is accurate to the best of my knowledge.

Form Completed By:_____